Thank you for completing the pre-enrollment questionnaire. You will be receiving notification advising you of the next steps in the enrollment process. Due to the confidentiality of some questions. Please ***do not mail*** this form to CVS Caremark.

Below is a summary of your responses

Download PDF

Pharmacy Provider Pre-Credentialing Questionnaire

Thank you for your interest in becoming a participating pharmacy provider with CVS Caremark. Pursuant to requirements set forth in 42 CFR 455, please complete the following questionnaire for membership consideration. This questionnaire must be completed and submitted in order for your pharmacy to move forward in the enrollment process.

A federal or state Medicaid agency (through its contracted managed care organizations and CVS Caremark) may terminate an agreement with a pharmacy provider if it determines that the provider did not fully and accurately make the disclosures required in this survey. 42 CFR 455.106. Additionally, false statements or misrepresentations of the required disclosures may be prosecuted under applicable federal or state laws. 31 USC 3729. [click here for details on the e-CFR]

DO NOT SELECT THE BACK ARROW ON YOUR BROWSER
Clicking on the browser back arrow button will terminate your session and result in having to restart the questionnaire.

INSTEAD USE the *forward >>* and *back <<* buttons located at the bottom of each page to navigate through the questionnaire.

!!Please complete all applicable questions to insure a faster enrollment process!!

To begin the Pre-Credentialing Questionnaire click the >> button at the bottom right hand corner of this page

To obtain Terms & Conditions for Medicare Part D Plan(s) please click the below link:
Medicare Part D Any Willing Provider Request
Note: you do not need to complete the Pharmacy Pre-Enrollment Questionnaire in order to receive Medicare Part D Terms / Conditions; however, the Pharmacy Pre-Enrollment Questionnaire will need to be completed if you wish to contract as a CVS/caremark member and participate in a Medicare Part D network for any of the Plans indicated

1) Pharmacy Information

NCPDP:	5906372
NPI:	1023363165
Pharmacy Doing Business As (DBA) Name:	Accu-Care Pharmacy
Pharmacy Legal/Corporate Name:	Safety and Health Technology LLC
Email address:	licensing@accucarepharm

2) Type of enrollment

- ○ New Pharmacy
- ○ Change of Ownership
- ◉ Current CVS Caremark Provider (Update)

3) Is 25% or more of your business mail order?

- ○ Yes
- ◉ No

4) Name of primary authorized contact for this pharmacy

First Name:	Marco
Last Name:	Aguillon
Job Title:	Authorized Official

5) Pharmacy Location

Name	Accu-Care Pharmacy
Address	3745 Highway 6
City	Sugar Land
State	TX
Zip Code	77478

6) Phone/Fax Number

GX1204.001

GOVERNMENT EXHIBIT 1204 4:18-CR-368

Defendant (2) Exhibit 85 No. 4:18-CR-368

Phone Number:	832-939-9052
Fax Number:	281-[illegible]

7) Is the pharmacy mailing address different from the physical address?

- ○ Yes
- ◉ No

9) Business Type

- ○ Corporation
- ○ Sole Proprietor
- ○ Partnership
- ◉ Limited Liability Company/Partnership (LLC/LLP)

10) Credentials

State License Number:	28027
State Licensed In:	TX
Medicaid ID (if applicable):	NA
DEA Number:	FA3312585

11) Ownership Information *(Source: 42 CFR 455.104)*

List the identity of *ANY PERSON* who has a direct or indirect ownership or control interest in the pharmacy provider (including corporate officers and directors). See 42 CFR 455.101 for the definition of "person with an ownership or control interest" and 42 CFR 455.102 for information regarding determination of ownership or control percentages.

	First Name:	Last Name:	% of Ownership	Address	City	State	Zip	Date of Birth MM/DD/YY	Social Security # (xxx-xx-xxxx)	Other Tax ID	Individual Provider NPI (if applicable)
1	Michael	Dieter	99	3745 Highway 6	Sugar Land	TX	77478	03/30/1990	636-16-0960		
2	Marco	Aguillon	1	3745 Highway 6	Sugar Land	TX	77478	08/22/1978	150-94-4465		
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
14											
15											
16											
17											
18											
19											
20											

12) Ownership Information (Source: 42 CFR 455.104)

List the identity of *ALL CORPORATE OWNERS* (company, corporation, partnership, etc) of this pharmacy that has a direct or indirect ownership or control interest in the pharmacy provider (including corporate officers and directors). See 42 CFR 455.101 for the definition of "person with an ownership or control interest" and 42 CFR 455.102 for information regarding determination of ownership or control percentages. The address for corporate entities must include, as applicable, primary business address, every business location, and P.O. Box address.

	Company Name	Address	City	State	Zip	Tax ID	% of Ownership	Organizational Provider NPI (if applicable)
1	S&HT Acquisitio	3745 Highway 6	Sugar Land	TX	77478	47-15677630	100	
2								

3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								

13) Relationship to Other Owners ***(Source: 42 CFR 455.104)***

Are any of the owners (individual or corporate) with an ownership or control interest in the pharmacy provider *RELATED* to another person with ownership or control interest in the pharmacy provider, If so, please list:

	Owner: First Name	Owner: Last Name	Relationship (e.g. spouse, child, sibling, brother/sister in-law)	Related Owner: First Name	Related Owner: Last Name	Individual Provider NPI (if applicable)
1						
2						
3						
4						
5						

14) Do any of the pharmacy owners (individual & corporate) own or have an ownership interest in *ANY OTHER PHARMACY PROVIDER* (other than the applicant pharmacy)?

- ○ Yes
- ◉ No

16) List all *MANAGING EMPLOYEES* of the pharmacy provider:
(Source: 42 CFR 455.104)

	First Name	Last Name	Address	City	State	Zip	Date of Birth MM/DD/YY	Social Security # (xxx-xx-xxxx)	Other Tax ID	Individual Provider NPI (if applicable)
Pharmacist In Charge	Lynh	Phan	3745 Highway 6	Sugar Land	TX	77478	12/16/1969	586-40-5894		
Other Pharmacist										
Other Pharmacist										
Other Managing Employee										
Other Managing Employee										

17) Significant Business Transactions #1 ***(Source: 42 CFR 455.105)***

Please provide information related to significant business transactions: Please provide the name and ownership information of all subcontractors, vendors, suppliers, etc. with whom the pharmacy provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request.

1) Type of subcontractor, vendor, or supplier

- ☐ Person
- ☑ Company

19) COMPANIES - Significant Business Transactions #1 ***(Source: 42 CFR 455.105)***

Please provide the name and ownership information of all *COMPANIES* who are subcontractors, vendors, suppliers, etc. with whom the pharmacy provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request.

	Company	Federal Tax ID	Street Address	City	State	Zip
1	Pharms LLC	46-3081048	4916 Main St. St	Houston	TX	77002
2						
3						
4						
5						

20) Significant Business Transactions #2 ***(Source: 42 CFR 455.105)***

List all significant business transactions between the pharmacy provider and any wholly owned supplier, or between the pharmacy provider and any subcontractor, during the 5-year period ending on the date of the request.

	Name of Subcontractor, vendor, supplier	Describe Significant Business Transaction
1	Pharms LLC	Administrative a
2		
3		
4		
5		
6		

21) Information on persons convicted of crimes ***(Source: 42 CFR 455.106)*****:**

Please list the identity of any person who:

(1) Has ownership or control interest in the pharmacy provider, or is an agent or managing employee of the pharmacy provider; and who also

(2) Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.

	First Name	Last Name	Relationship to pharmacy (e.g., owner –director or officer, agent, or managing employee)	Individual Provider NPI (if applicable)
1				
2				
3				
4				

Is your pharmacy registered/affiliated with a compounding supplier? (e.g. PCCA, Medisca, Letco, Freedom, etc.)

- (•) Yes
- ( ) No

Please list all suppliers with which your pharmacy is registered/affliated:

Supplier 1	Medisca
Supplier 2	Freedom
Supplier 3	
Supplier 4	
Supplier 5	

Does the pharmacy have a dedicated lab/area for compounding?

- (•) Yes
- ( ) No

Does your pharmacy have dedicated technicians for compounding only?

- ( ) Yes
- (•) No

Does your pharmacy have any of the following compound equipment?
(please check all that apply)

- [x] unguator
- [ ] hot plate
- [ ] homogenizer
- [x] ointment mill
- [ ] tube sealer
- [x] capsule filling system

Does your pharmacy anticipate filling more than 10% of retail claims as non-sterile compounds?

- ( ) Yes
- (•) No

What types of compounds do you make (or anticipate making for a new pharmacy)?
(please check all that apply)

- [x] Topical analgesics
- [x] Hormone Replacement Therapy (HRT)
- [ ] Sterile compounds - TPNs, IV antibiotic
- [x] Scar cream
- [x] Other - Specify
  Mouthwash, Nasal Irri

This concludes the online questionnaire. Please be sure your answers are complete. Your changes will be saved in the event that you are not ready to submit this form. Your answers will be saved and you can finalize the form at a later time. Please only submit this form once. Submitting multiple times may invalidate some of your responses.

The forward arrow button at the bottom right will submit the questionnaire. After submitting you will have the option to save a copy of this form. Please do not mail a copy of this form to CVS Caremark.

Please allow up to 7-10 business days upon submission of questionnaire for a response via mail for details on how to complete the enrollment process.

Please note: A federal or state Medicaid agency (through its contracted managed care organizations and CVS Caremark) may terminate an agreement with a pharmacy provider if it determines that the provider did not fully and accurately make the disclosures required in this survey. 42 CFR 455.106. Additionally, false statements or misrepresentations of the required disclosures may be prosecuted under applicable federal or state laws. 42 USC 3729.